ADVISORY NO. 2 REGARDING 1999 LEGISLATION

References in this Advisory to "Section" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as amended, California Health and Safety Code Sections 1340 et seq. References to "Rule" are to the regulations promulgated pursuant to the Act at Title 10 of the California Code of Regulations, commencing at Section 1300.43.

This Advisory provides clarification regarding the extent of information and documents to be filed by health care service plans ("plans") to demonstrate compliance with 1999 legislation. This Advisory also includes amendments to the Department's requests contained in the Department's April 5, 2000 letter to plans ("April 5 Letter") and subsequent comments issued by the Department regarding plan responses to the April 5 Letter as communicated to plans in attendance at the Department's August 22, 2000 meeting with full service plans and the August 29, 2000 meeting with specialized plans. Please note that this Advisory does not summarize the entirety of the information communicated at the above-referenced meetings, but is intended to provide information to facilitate the demonstration of compliance by plans with respect to issues on which plans have expressed confusion or concern.

AB 12

1. The Department's April 5, 2000 letter requested that plans specify in their respective evidences of coverage ("EOCs") the circumstances under which second medical opinions will be authorized. Plans should file language that identifies the five reasons set forth in Section 1383.15. The Department will not require plans to include language that identifies additional reasons or bases upon which a second medical opinion may be granted by the plan.

2. Plans, and not their contracted providers, are required to incur the cost of out-of-plan referrals for second medical opinions, unless otherwise separately negotiated and reflected in an amended provider contract.

AB 88

1. With respect to the disclosures to be included in subscriber documents that identify coverage of the services required pursuant to AB 88, plans should file language that mirrors the language of Section 1374.72(a). The Department will not accept language that limits the definition of, or the coverage of, severe mental illness to only the nine specific conditions listed in AB 88.

2. The Department is developing an advisory ("AB 88 Advisory") intended to provide guidance on how a full service plan can demonstrate compliance with AB 88 under circumstances where a group subscriber has contracted directly with a specialized plan to provide AB 88 services and does not want to pay the full service plan increased premiums for the same benefits. The AB 88 Advisory will identify several models of contractual relationship between full service plans and specialized behavioral health (mental health) plans. The Advisory will also identify issues of concern and describe the information and

documents needed to resolve the issues of concern. The AB 88 Advisory will be placed on the Department's Internet web site.

AB 285

In lieu of the previously requested list of nurses staffing the telephone medical advice entity, plans should file an affirmative representation that the telephone medical advice entity is subject to the plan's oversight and monitoring processes, that the staff of the telephone medical advice entity are licensed as required by AB 285 and that the telephone medical advice entity is in compliance with the requirements of AB 285.

AB 416

To the extent a specialized plan and its contracted providers do not, in the ordinary course of business, generate, request, convey, use or come into possession of mental health treatment records as described in Civil Code Section 56.104, the plan should file an affirmative representation to that effect. The plan should further represent that the plan and its contracted providers will comply with the requirements of AB 416 if such records should ever come into their possession.

SB 189

1. The emergency regulations relating to handling of urgent grievances are in effect and the plans are expected to be in compliance. The Department is currently open on a 24 hours-per-day, seven days-per-week basis to receive urgent complaints regarding plans. The emergency regulations require the plans to provide a contact person with authority to resolve urgent grievances who will be available on a 24 hours-per-day, 7 days-per-week basis and to identify two additional persons to serve as back-up urgent contacts. The plans must file the names and other information required by the regulations for all three people. If a plan has not already filed the required information, it must do so immediately. The filing should be made separately from 1999 legislation amendments, with a narrative description in Exhibit E-1 of the changes to the plan's processes and documents and with the recitation of personnel contact information in Exhibit W.

2. The specialized plans indicated that there was still confusion regarding application to specialized plans of SB 189 (Section 1370.4, currently in effect) and AB 55 (Section 1374.30, effective January 1, 2001). The Department will apply both provisions to a specialized plan to the extent the services of the specialized plan (1) involves the practice of medicine or (2) are provided pursuant to a contract with a full service plan. In addition, a denial of a requested service on the basis that it is experimental or investigational will trigger application of Section 1370.4. Specialized plans asserting that they are outside the scope of Section 1370.4, but which do exclude coverage of experimental or investigational services must provide an affirmative representation that, although the exclusion is contained in one or more plan documents, the plan does not deny services on that basis, and if a denial is ever made on that basis, the plan will comply with the requirements of Section 1370.4.

SB 349

Plan documents that contain a definition for "emergency," must be amended for compliance with SB 349, reflecting in the definition the changes to Health & Safety Code Section 1317.1. Plans may choose to include within the EOCs two definitions for emergency that serve to clarify the emergency services that are covered by the plan. For example, a dental plan may include a definition for medical emergency that is consistent with Section 1317.1 which may include the plan's clarification that medical emergencies are not covered, and a separate definition for dental emergency, which is a covered benefit of the dental plan. Amending definitions to reflect the inclusion of psychiatric emergencies does not constitute a mandate that providers and facilities without the capability must treat psychiatric emergencies given the express language of Section 1317.1(a)(1) and Section 1317.1(a)(2)(A) that state "within the capability of the facility." With respect to requested amendments of plan documents disclosing the amended definition of emergency, plans may file proposed language consistent with Section 1317.1 together with an affirmative representation that, upon receiving the Department's approval of the language, all plan documents will be amended to reflect the new definition.

SB 1185

To the extent a specialized plan and its contracted providers do not, in the ordinary course of business, generate, request, convey, use or come into possession of genetic information as defined in Section 1374.7, the plan should file an affirmative representation to that effect. The plan should further represent that the plan and its contracted providers will comply with the requirements of SB 1185 if such records should ever come into their possession. At the August 29, 2000 meeting, a genetic test for evaluating risk for periodontal disease was identified. Dental plans should include an affirmative representation that neither the plan or its providers generate, request, convey, use or come into possession of this information, or use it to deny coverage or to discriminate in the care or costs for enrollees.

GENERAL MATTERS:

1. Meet & Confer: The Department has offered to meet with plans that have not yet received initial comments regarding the plan's response to the April 5 Letter, either in person or by telephone at the plan's preference, to discuss and resolve the issues of concern raised in the filing. The conference is offered to facilitate a swift communication and resolution of outstanding issues of concern raised in the filing. Plans are not required to accept the conference in lieu of written comments, and are requested to advise reviewing counsel if they wish to decline such conference. Issues not resolved through the meet and confer process will be reflected in a comment letter.

2. Deadline for Plan Responses - Full Service Plans: For full service plans that received an initial comment letter before the August 22, 2000 meeting, the deadline for responding is September 21, 2000 (30 days after the August 22, 2000 meeting). For plans that did not receive a comment letter before the meeting, and avail themselves of the meet and confer opportunity, the deadline for responding will be 30

days after they meet and confer with reviewing counsel. For those that prefer written comments the deadline will be 30 days after the date of the comment letter.

3. Deadline for Plan Responses – Specialized Plans: For specialized plans that received an initial comment letter before the August 29, 2000 meeting, the deadline for responding is September 28, 2000 (30 days after the August 29, 2000 meeting). For plans that did not receive a comment letter before the meeting, and avail themselves of the meet and confer opportunity, the deadline for responding will be 30 days after they meet and confer with reviewing counsel. For those that prefer to receive written comments the deadline will be 30 days after the date of the comment letter.

4. Limitation of review to 1999 legislation issues: Counsel review of plan responses to the April 5 Letter is intended to be limited to issues related to 1999 legislation. Some comments were issued regarding those filings identifying compliance issues that are not related to 1999 legislation. To the extent that these non-1999 legislation issues are not resolved in the Plans' response to the initial comment letters, these issues will be severed from the scope of review of 1999 legislation and will receive separate follow up by the Department as appropriate. See also the following paragraph regarding scope of Department approval of amendments filed in response to the April 5 Letter.

Scope of Approval: Upon resolution of all issues related to compliance with 1999 legislation, in accordance with the new amendment process, counsel will issue affirmative approval letters. The approval letters will contain language limiting the approval to plan documents and processes that relate to compliance with 1999 legislation, and to the extent that (1) the changes were specifically identified in the Exhibit E-1 narrative and (2) the supporting documents filed under the relevant exhibits highlighted the amendments to the plan documents as required pursuant to Rule 1300.51.2.